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Chief Executive Officer

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December 30, 2010

To: Mayor Michael D. Antonovich  
Supervisor Gloria Molina  
Supervisor Mark Ridley-Thomas  
Supervisor Zev Yaroslavsky  
Supervisor Don Knabe

From: William T Fujioka *William T Fujioka by [Signature]*  
Chief Executive Officer

### KATIE A. IMPLEMENTATION PLAN QUARTERLY UPDATE

On October 14, 2008, your Board approved the Katie A. Strategic Plan (Strategic Plan), a single comprehensive and overarching vision of the current and planned delivery of mental health services to children under the supervision and care of child welfare as well as those children at-risk of entering the child welfare system. The Strategic Plan provides a single roadmap for the Countywide implementation of an integrated child welfare and mental health system, in fulfillment of the objectives identified in the Katie A. Settlement Agreement, to be accomplished over a five-year period, and offers a central reference for incorporating several instructive documents and planning efforts in this regard, including:

- Katie A. Settlement Agreement (2003);
- Enhanced Specialized Foster Care Mental Health Services Plan (2005);
- Findings of Fact and Conclusions of Law Order (2006), issued by Federal District Court Judge Howard Matz;
- Health Management Associates Report (2007); and
- Katie A. Corrective Action Plan (2007).

The Strategic Plan describes a set of overarching values and ongoing objectives, offers seven primary provisions to achieve these objectives, and lays out a timeline by which these strategies and objectives are to be completed. The seven primary provisions include:

*"To Enrich Lives Through Effective And Caring Service"*

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<b>KATIE A. STRATEGIC PLAN OBJECTIVES</b>	
1. Mental Health Screening and Assessment	2. Mental Health Service Delivery
3. Funding of Services/Legislative Activities	4. Training
5. Caseload Reduction	6. Data and Tracking of Indicators
7. Exit Criteria and Formal Monitoring Plan	

The Strategic Plan also provides that the Departments of Children and Family Services (DCFS) and Mental Health (DMH) inform your Board regarding any revisions to the implementation of the Strategic Plan. Since the Strategic Plan encompasses the initial Enhanced Specialized Foster Care Mental Health Services Plan and the Katie A. Corrective Action Plan (CAP), this report will also describe any significant deviations from the planning described in those documents.

Previous quarterly reports were submitted on implementation activities in June 2009, September 2009, March 2010, July 2010, and September 2010. This memo serves as the sixth update to our progress in implementing the Strategic Plan. Due to the time required to compile the reports, particularly to obtain updates for the "Data and Tracking of Indicators" section, we will be transitioning to semi-annual reporting in 2011. Accordingly, the next report will be submitted on June 30, 2011.

### **Implementation Support Activities**

- Greg Lecklitner, DMH District Chief, participated as a member of the Katie A. State Negotiations Team, which is working toward a settlement of the Katie A. State Case. The interest-based, decision-making process used in this matter has completed its work and the Special Master will soon be submitting recommendations to the Court. There is a possibility of a settlement agreement which would be of significant support to the work of the County in this matter.
- Training for the redesigned Coordinated Services Action Team (CSAT) and revised Child Welfare Mental Health Screening Tool (MHST) is complete for DCFS and DMH staff located at the offices of Belvedere, Santa Fe Springs, Wateridge, Compton, Lancaster, Palmdale, Pomona, El Monte, Emergency Response Command Post (ERCP), and Asian Pacific and American Indian units. Official implementation of CSAT and the revised MHST has begun in the Belvedere, Santa Fe Springs, Wateridge, Compton, Lancaster, Palmdale, Pomona, and El Monte offices.

- The Real Time Notification and Expedited Response Protocol, and Exodus Recovery Urgent Care Center (Exodus) Memorandum of Understanding (MOU) are currently being reviewed by County Counsel. Pending finalization of the MOU and the development of formal policy, many activities establishing joint, timely and skilled responses from DCFS and DMH staff to DCFS children experiencing a mental health crisis, are occurring as follows:
  - The DCFS/DMH Data Cube is now available to Psychiatric Mobile Response Team (PMRT) staff and other clearance procedures are in place to identify DCFS involvement for any child/youth who is the subject of a PMRT call;
  - Expedited and joint response between an Emergency Response (ER) Children's Social Worker (CSW) and PMRT for any child/youth who is the subject of a PMRT call and alleged abuse/neglect is available 24 hours a day/7 days a week, including regular business hours (Monday – Friday 9:00 a.m. to 5:00 p.m.) and after business hours;
  - Coordination of care and treatment will occur between the existing CSW and PMRT and will begin the next business day for any DCFS child/youth who is the subject of a PMRT call without allegations of abuse/neglect. In addition, the process to track and monitor this activity is in development;
  - DCFS 101 Training provided to Exodus management and staff as well as PMRT staff; and
  - Amendment of the mental health contract with Exodus to allow them to provide services to children and youth ages 13 and above.
- LAC+USC Emergency Department (ED), LAC+USC Medical Hub, Violence Intervention Program (VIP), DCFS, and DMH staff have collaborated to establish protocols to identify DCFS youth admitted to the ED or the hospital for mental health reasons and/or a psychiatric hold, the service delivery of such clients, and joint discharge planning.
- Development and implementation of the Core Practice Model (CPM) and enhanced training for DMH and DCFS staff to improve quality of assessments and interventions, and encourage teaming, with a shared focus on the needs and strengths of children and families.
- Collaboration between DCFS Child Welfare Mental Health Services (CWMHS) Division and the Bureau of Information Services management resolved the

long-standing technical challenges to permit the uploading of over 3,000 Psychotropic Medication Authorization (required for the administration of psychotropic medication) documents to the Child Welfare Services/Case Management System (CWS/CMS).

- DCFS and DMH Wraparound Administrations have begun a series of technical assistance site visits with Wraparound providers in order to improve the utilization of Early Periodic Screening Diagnosis and Treatment (EPSDT) funds associated with Wraparound programs. These site visits will be performed across all 34 Wraparound agencies over the course of the next year.
- To improve the maximization of Katie A. contracts, DMH Child Welfare Division staff, in conjunction with DMH service area administrations, initiated a series of technical assistance site visits with Katie A. mental health providers to examine their claiming practices. These visits have been completed for Service Planning Area (SPAs) 1, 3, and 4 and will continue until all 64 Katie A. providers have been visited.
- DMH has contracted with three mental health providers to deliver mental health services consistent with the CPM to Los Angeles County DCFS children placed in San Bernardino County.
- DMH, DCFS, and the Chief Executive Office (CEO) have convened workgroups to improve the implementation of the Treatment Foster Care (TFC) program and to address the mental health needs of those children placed outside of Los Angeles County.
- Department representatives participated in a two-day meeting with the Katie A. Advisory Panel on December 15 and 16, 2010 to discuss the CPM, intensive mental health services for children in Foster Family Agencies (FFAs) and D-Rate homes, Quality Services Review (QSR), TFC, Wraparound Case Rate, and overall Strategic Plan implementation issues.

Additional implementation activities associated with the Strategic Plan, organized according to the basic elements of the Plan, are described below.

## **OBJECTIVE NO. 1**

### ***Mental Health Screening and Assessment***

The Strategic Plan describes a systematic process by which all children on new and currently open DCFS cases will be screened and/or assessed for mental health service needs. Below are the Screening and Assessment components of the Plan:

- *Medical Hubs*
- *Multidisciplinary Assessment Team*
- *Benefits Establishment*
- *Team Decision-Making*
- *Specialized Foster Care*
- *Coordinated Services Action Team*
- *Referral Tracking System*
- *Consent/ Release of Information*
- *D-Rate*
- *Resource Management Process*

#### **Medical Hubs**

In Fiscal Year (FY) 2009-10, 80 percent of newly detained children received an initial medical examination at a Medical Hub (Hubs).

DCFS continues to improve child health outcomes for DCFS children by ensuring that 100 percent of the priority populations of DCFS children are referred to and served by the Hubs. DCFS has defined the priority populations as:

- Newly detained children placed in out-of-home care;
- Children who are in need of a forensic evaluation to determine abuse and/or neglect; and
- Children with special health care issues that need a follow-up exam, i.e., diabetes, hemophilia, developmental delay, etc.

On September 15, 2010, a memorandum was issued by the DCFS Director and Medical Director which mandated all DCFS staff to refer all newly detained children to a Hub for initial medical examination. In addition to presentations held in August and September 2010 on the DCFS Utilization of the Medical Hubs Procedural Guide, representatives from DCFS, Department of Health Services (DHS) and DMH administration hosted local meetings to strengthen the referral to and the use of the Hubs for the priority populations.

Further, the County has moved forward with the development of the Enterprise Medical Hub (E-mHub) system to strengthen the continuity of care by the DHS-operated Hubs and to improve information sharing between DCFS and the Hubs. The E-mHub Project Workgroup continues to convene weekly to provide system development

recommendations to the contracted vendor, Saga Technology Inc. Currently, the Workgroup is developing the User Acceptance Testing for system functionality. Testing of approximately five categories is scheduled to be complete in December 2010, with full implementation in June 2011.

### **Coordinated Services Action Team Redesign Rollout and Training Schedule**

On May 1, 2009, CSAT was implemented in SPA 7 (Belvedere and Santa Fe Springs). On August 1, 2009, CSAT was implemented in SPA 6 (Compton, Wateridge, and Vermont Corridor). SPA 1 (Lancaster and Palmdale) implemented CSAT in September 2009, and SPA 3 (El Monte and Pomona) implemented CSAT on April 1, 2010.

In response to the January 19, 2010 motion from Supervisors Molina and Knabe, DCFS and DMH staff reviewed a sample of 51 children's cases from the DCFS Santa Fe Springs Regional Office for mental health screening, referral, and start of mental health services. The cases were randomly selected from newly detained children (25 cases) and newly opened non-detained children (26 cases). As a result of the case review, the Child Welfare MHST, the Referral Tracking System (RTS), the CSAT Screening and Assessment Policy, and the related DMH policy were revised to ensure the timely screening for, referral to, and provision of mental health services according to acute, urgent, and routine mental health needs.

The MHST was revised to distinguish the acuity of a child's mental health needs and was piloted in SPAs 7, 6, 1, and 3 in May 2010. The pilot results revealed that 76 percent of the CSWs indicated that the revised MHST was easier to complete. In December 2010, the MHST was further revised to refine language that misleadingly indicated a child's need for urgent assessment from DMH, who subsequently determined the mental health need existed, but was not urgent. Subsequently, the RTS was revised to track compliance and timelines for screening, referral, and receipt of mental health activities for newly detained children, non-detained children, and open cases.

In addition, the DCFS CSAT mental health screening and referral policy was revised to reflect the CSAT redesign process. CSAT staff and regional administration convene CSAT "pre-meets" prior to beginning training in each office. The pre-meet familiarizes regional management with the CSAT process and identifies their respective strengths and challenges, ensuring that training will be targeted to address the specific needs of each regional office. "Pre-meets" for SPA 4 and Covina Annex began in October 2010 and ERCP in November 2010.

CSAT redesign training was provided to SPA 7 in August 2010 and the revised mental health screening, referral, and service linkage process and RTS system “trial month” phase was implemented on September 1, 2010. All CSAT previously trained offices have been retrained and are now implementing the CSAT redesign. Data from SPA 7’s trial month of CSAT redesign implementation will be reported to the Board in the December Monthly Report on the Mental Health Screening Process.

### **CSAT SUCCESS STORY**

An ER CSW in Palmdale referred four children to Family Preservation (FP) for mental health services. Due to the lack of Spanish speaking providers in the Antelope Valley, the children were placed on a waiting list. As the ER CSW continued working with the family, it was determined that one of the children required urgent linkage to mental health treatment. Subsequently, the ER CSW consulted with the Service Linkage Specialist (SLS) and DMH FP to discuss mental health treatment options to prevent the child from being removed from their home, and as a result, DMH co-located staff is providing mental health services to all four children. The collaboration and teamwork by all involved made it possible to ensure the children remained at home and that their needs were met. The redesigned training rollout per office is depicted in Table 1.

**Table 1: CSAT Redesign Training and Rollout Schedule**

<b>DCFS Office</b>	<b>Training Month</b>	<b>Trial Month</b>	<b>CSAT Roll Out</b>	<b>RTS Report to Board</b>
Belvedere, Santa Fe Springs	Aug. 2010	Sept. 2010	Oct. 2010	Dec. 2010
Compton, Wateridge, Vermont Corridor	Aug. – Sept. 2010	Oct. 2010	Nov. 2010	Jan. 2011
Palmdale, Lancaster, Pomona, El Monte	Oct. 2010	Nov. 2010	Dec. 2010	Feb. 2011
Covina Annex (Asian Pacific/American Indian Units only), Metro North	Nov. 2010	Dec. 2010	Jan. 2011	Mar. 2011
ERCP	Dec. 2010	Jan. 2011	Feb. 2011	Apr. 2011

West Los Angeles, Deaf Services, Pasadena	Jan. 2011	Feb. 2011	Mar. 2011	May 2011
Lakewood, Torrance	Feb. 2011	Mar. 2011	Apr. 2011	June 2011
Glendora	Mar. 2011	Apr. 2011	May 2011	July 2011
Medical Case Management Services	Apr. 2011	May 2011	June 2011	Aug. 2011
San Fernando Valley, Santa Clarita, West San Fernando Valley	May 2011	June 2011	July 2011	Sep. 2011

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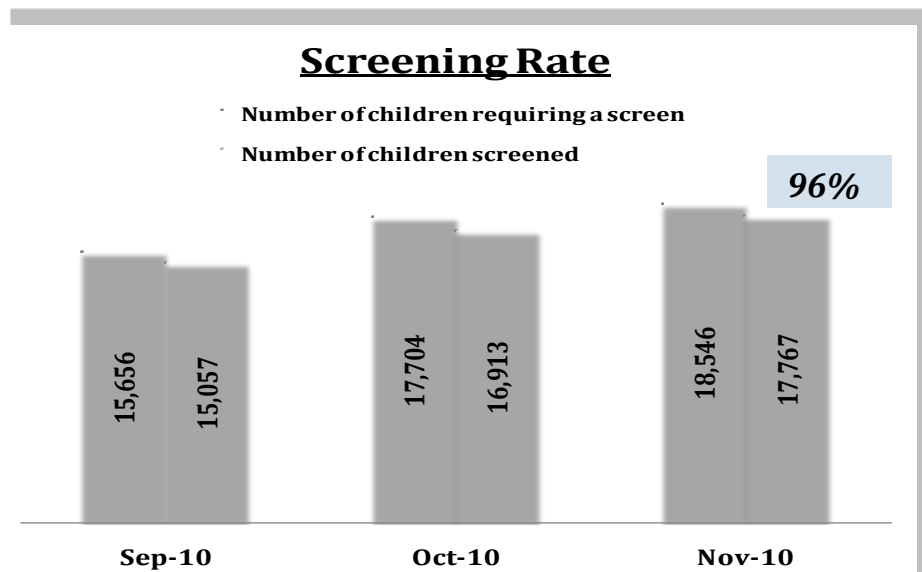
### **Referral Tracking System**

The RTS is operational in DCFS and DMH in a total of nine DCFS regional offices in SPAs 1, 3, 6, and 7. The RTS required redesign to reflect changes in the CSAT policy and procedures. The redesigned RTS has provided initial data on the completion of the mental health tool for screening, referral, and start of service activity for children with acute, urgent, and routine mental health needs in SPA 7 on September 1, 2010 and in SPA 6 on October 1, 2010.

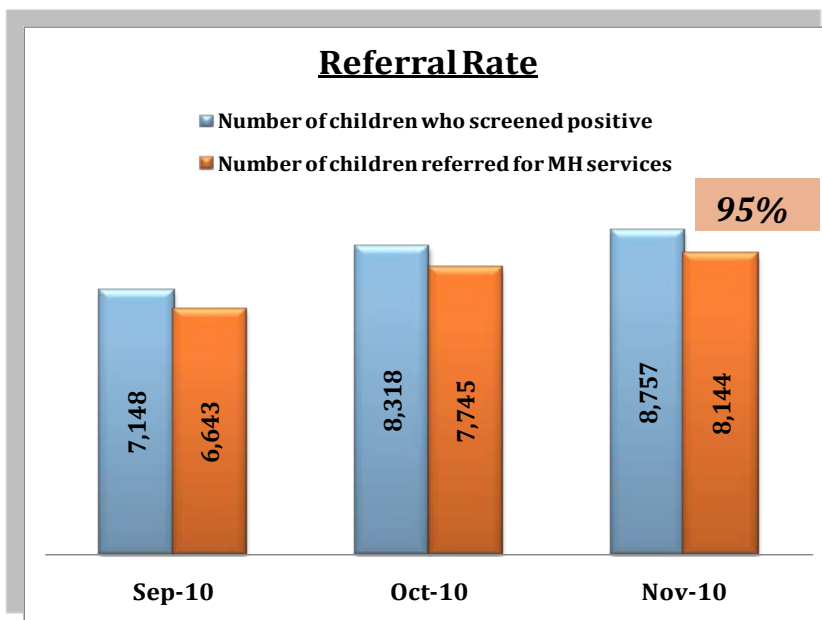
In addition, the RTS will track the annual re-screening of children in open cases with previous negative screens and not receiving mental health services. The first revised report tracking mental health acuity and response in SPA 7 will be submitted to the Board on December 30, 2010.

As of the November 30, 2010 CSAT/RTS Monthly Report, 17,767 children received mental health screens since implementation on May 1, 2009, yielding a 96 percent screening rate.\* The mental health screening rate is tracked through the RTS for referral and mental health service linkage.





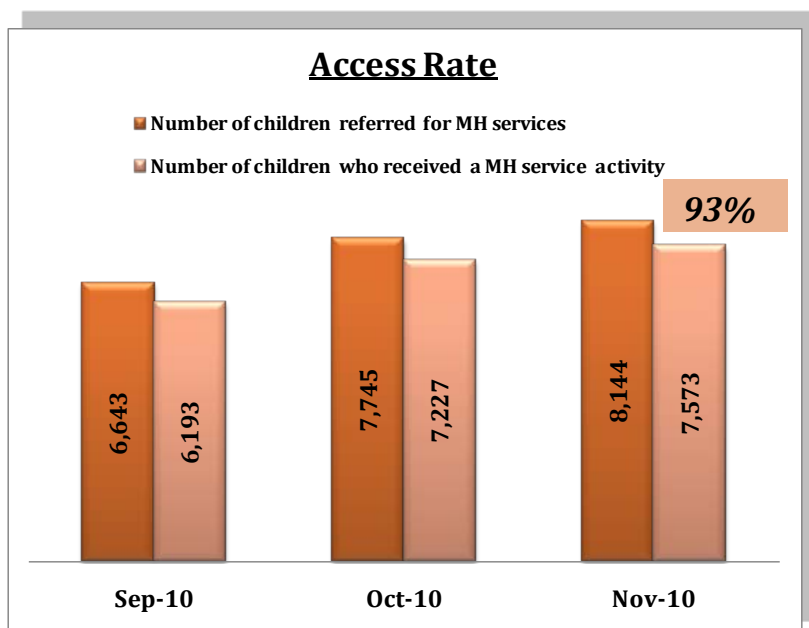
\*The number of children that required screens is defined as a) the number of newly detained children (Track 1) with a case opening in the month; b) the number of newly opened non-detained children (Track 2) with a case opening in the month; c) the number of children in an existing open case (Track 3), not currently receiving mental health services, with a case plan update due or a behavioral indicator identified requiring the completion of a Child Welfare Mental Health Screening Tool (MHST) within the month. Out of the total number of children reported, the number of children requiring screens was reduced by the number of children in cases (Tracks 1, 2, and 3) that were closed during the screening, referral, and service linkage process.



As of the November 30, 2010 Monthly Report, out of the **8,757** children who screened positive, **8,144** children were referred for mental health services at a **95 percent** referral rate.\*\*

\*\* The rate of referral reflects the number of children who screen positive minus the number of children who are determined to be privately insured divided by the number of children referred to mental health services. The number of children referred for mental health services can be affected by the number of children with a closed case, deceased, and/or AWOL at the time of referral or still pending referral.

As of the November 30, 2010 Monthly Report, out of **8,144** children referred for mental health services, **7,573** children received a mental health service activity within 30 days of the referral at a **93 percent** access rate.



### **Multidisciplinary Assessment Team**

In September 2010, 83 percent of all Multidisciplinary Assessment Team (MAT) eligible newly detained children Countywide were referred to MAT. From October 2009 to September 2010, there were 4,806 MAT referrals and 3,552 MAT assessments completed.

In September 2010, 11 DCFS offices referred 90 to 100 percent of all MAT eligible children, two DCFS offices referred 80 to 89 percent of all MAT eligible children, and six offices referred between 70 to 79 percent of all MAT eligible children. All eight SPAs are referring over 70 percent of eligible children and SPA 1 referral rates have increased since the last report. The rate of MAT compliance is depicted in Table 2.

Table 2: MAT Compliance	MAT Eligible	MAT Referred	Percent
SPA 1	41	31	76%
SPA 2	91	77	85%
SPA 3	116	100	86%

SPA 4	24	23	96%
SPA 5	13	13	100%
SPA 6	107	78	73%
SPA 7	55	49	89%
SPA 8	61	52	85%
Total number of DCFS MAT referrals:	<b>508</b>	<b>423</b>	<b>83%</b>

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\* Cumulative includes all September 2010 MAT referrals within each DCFS office and SPA.

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MAT staff (DMH, DCFS, and MAT agencies) meet at the SPA level on a monthly basis to address MAT issues specific to the regional office and the providers in that SPA. A MAT Best Practice Workgroup, comprised primarily of experienced MAT providers, and managers from both departments have worked to standardize and streamline the MAT process by redesigning the Summary of Findings (SOF) format and have developed new best practice guidelines. One of the workgroup's goals is to improve the quality of MAT reports. To achieve this goal, DMH has provided Strength and Needs-Based Assessment trainings to MAT assessors and both departments are working to develop MAT trainings related to form completion, documentation, and billing.

In addition, the Best Practice Workgroup has worked to overcome barriers that prevent MAT agencies from completing the SOF in time for Court consideration at the dispositional hearing. DCFS MAT Coordinators are closely monitoring the dispositional date of cases referred for MAT and are sending reminders to the MAT agencies. In addition, DCFS MAT Coordinators work closely with the Dependency Court attorneys to ensure that children have the appropriate consents to receive needed mental health services, while DMH MAT Coordinators are closely monitoring the quality of the MAT SOFs and consulting with MAT providers to improve the quality of the reports. MAT staff and other stakeholders have also met to discuss the needs for timely linkage to mental health services. This meeting resulted in the creation of the MAT Linkage Workgroup. This workgroup is tasked with ensuring that children with mental health needs are linked to appropriate services in a timely manner. The guidelines have been created so that each MAT agency understands its new responsibility regarding timely and appropriate linkage to mental health services.

DMH and DCFS have issued a MAT Program Practice Guidelines document that outlines the scope of work for MAT providers, quality improvement protocol, MAT Quality Assurance checklist, and MAT CSW Interview Survey. These protocols are now being implemented in an effort to evaluate and improve the quality of the MAT program.

A preliminary study was conducted with one MAT assessor per SPA utilizing the revised SOF format. Overall feedback from the MAT assessors was very positive as they found the new format to be user-friendly, guided them to be more strengths/needs-based with the child and family, and allowed for more teaming with CSWs and families. As a result, the Best Practice Workgroup plans to implement the revised SOF form Countywide and will coordinate the implementation with aforementioned MAT trainings.

To date, DMH MAT Coordinators have completed a total of 247 MAT Quality Improvement (QI) Checklists. The checklists represent findings based upon a review of the MAT SOF from all eight SPAs. The MAT QI Checklist calls for yes/no responses within eight domains. In addition, DMH MAT Coordinators have completed a total of 141 MAT CSW Interview Surveys. The MAT CSW Interview Surveys calls for yes/no responses within seven domains. The results of the MAT QI Checklists and CSW Interview Survey are summarized below.

Results within MAT QI domains (April 2010 to November 2010)

- 86 percent of the SOFs reviewed showed that the assessors demonstrated reasonable efforts to engage all the stakeholders in multidisciplinary activities to support the information gathering/assessment process;
- 87 percent showed the SOF Report adequately assessed all of the MAT domains of functioning;
- 90 percent showed the SOF Report contained adequate description and information;
- 88 percent showed the SOF final report was completed within 45 days;
- 96 percent showed the strengths of the children, family, and other caregivers were adequately described;
- 92 percent showed the needs of the children, family, and other caregivers were adequately described;

- 94 percent showed the recommendations made in the report were consistent with the assessment information; and
- 97 percent showed the recommendations were specific enough to be efficiently implemented.

Overall, 91 percent of the individual domain ratings were positive.

Results within DMH MAT SOF CSW Interviews (April 2010 to November 2010)

- 85 percent are able to work effectively with the MAT assessor to ensure all relevant information is included in the report;
- 96 percent are satisfied with the extent to which they are able to participate in the SOF meeting;
- 91 percent reported that the SOF Report presented at the SOF meeting provided additional insight and information;
- 89 percent reported that the SOF Report assisted with the development of the service plan with the child(ren);
- 85 percent reported that the SOF Report assisted with the development of the service plan with the family;
- 83 percent reported that the SOF Report further supported the caregivers; and
- 67 percent reported that the SOF Report assisted in the preparation of their report recommendations to the court.

Overall, 85 percent of the individual domain ratings were positive.

**Consent/Release of Information**

DCFS and DMH, with their respective County Counsels, developed procedures and forms to provide for the consent of mental health services for referred children, as well as the authorization to release protected health information for purposes of children's care and coordination of services. The newly revised authorization to release protected health information became available to DCFS staff in English and Spanish in November 2010. Consent forms and standardized Court language that incorporated recommendations from the Children's Law Center (CLC), the Los Angeles Dependency

Lawyers, County Counsels, Regional Center, and DMH and DCFS management are close to final approval. In addition, CLC is in the process of finalizing a letter intended to provide an explanation regarding consent and protected health information. This letter is also to clarify what information providers may and may not share with DCFS and DMH staff for purposes of children's care and the coordination of services. The DCFS Training section will provide training to staff from both departments on the revised release of information and consent forms.

The DMH Practice Guidelines related to consultation requests involving adult mental health information are near completion and being reviewed by the DMH Quality Assurance Division. The Guidelines include information on the formation of the multidisciplinary teams that may allow DMH co-located staff and service providers to share adult mental health information to assist DCFS in providing protection to children and support to families. DCFS has agreed to create a comparable policy to clarify which situations, within this context, merit consultation with DMH and what information can be shared.

### **Benefits Establishment**

In August 2009, the CSAT team of MAT Coordinators, SLS, and CSAT clerks were given access to the Medi-Cal Eligibility Data System (MEDSLite) benefits establishment system. MEDSLite is a condensed version of the Medi-Cal Eligibility Data System (MEDS) that assists its users in quickly determining a child's Medi-Cal eligibility status. DCFS has developed a Benefits Establishment User Guide for SLS and MAT Coordinators that serves as an instructional guide for the use of MEDSLite, incorporating information that applies to programs available to DCFS families. The timely determination and accuracy of a child's benefits assist the DCFS and DMH staff to link an identified child to the most appropriate mental health services for all new and existing cases for CSAT implemented offices.

Although the MEDSLite system is helpful in providing a child's Medi-Cal eligibility status "at a glance", one of the limitations of the system is that it does not provide the issue date of a child's Medi-Cal card, needed most by DMH providers for mental health service billing. Therefore, DCFS and DPSS have developed a productive partnership through the use of DPSS Linkages staff to obtain and secure Medi-Cal services for children without Medi-Cal that are otherwise eligible.

### **D-Rate**

In addition to the D-Rate Program's continued work to review and ensure mental health services for D-Rate children, the duties of the DCFS D-Rate Evaluators have been expanded to include psychotropic medication monitoring for all DCFS children,

psychiatric hospital discharge planning, special placement requests and approvals, and service coordination for other high-need children.

A recent study conducted by DMH showed that 88 percent of the children placed in D-Rate homes were receiving mental health services and that 35 percent of those receiving mental health services were enrolled in an intensive home-based program, such as Wraparound or Full Service Partnerships. In addition, DMH and DCFS D-Rate staff have been working together to identify D-Rate children not receiving mental health services and promoting service linkages. As of October 2010, there were a total of 1,375 children in DCFS care who were receiving a D-Rate, a number that has been gradually declining over the last several years.

### **Team Decision-Making/Resource Management Process**

DCFS has completed 4,045 Team Decision-Making (TDM) meetings from July through September 2010, a decrease from the previous three months due to temporary reassignments to the ER Over 60 Days Project (April 2010 to June 2010). Additionally, DCFS has completed a total of 275 Resource Management Process (RMP) TDMs on 62 percent of youth entering a group home, 59 percent of youth replaced, and 61 percent of youth exiting a group home. This was an increase of 114 RMPs from the previous three months (April 2010 to June 2010).

### **Specialized Foster Care**

The DMH Specialized Foster Care (SFC) co-located staff responds to requests for consultation from CSWs, provides referral and linkages to community-based mental health providers, and participates in the CSAT process in those offices where CSAT has rolled out. Moreover, all SFC co-located clinicians were trained in Trauma Focused Cognitive Behavior Therapy, a brief evidence-based treatment for children exposed to trauma, and provide this treatment on a case-by-case basis. Currently, DMH has 178 co-located staff in 18 DCFS regional offices.

In addition, DMH co-located staff participates in a variety of shared practices with DCFS, including TDM meetings, RMPs, MAT SOF meetings, case conferences, and numerous training activities to improve their ability to support DCFS. DMH co-located staff has recently participated in a training to improve their ability to assess and treat children ages birth to five years of age and to properly identify children's strengths and needs, consistent with the CPM.

## **OBJECTIVE NO. 2**

### ***Mental Health Service Delivery***

DMH has been working with its provider community to improve capacity and utilization of mental health services, particularly among those providers, now totaling 64, who have received a Katie A. related contract (including Wraparound, MAT, TFC, Comprehensive Children's Services Program, and Basic Mental Health Services). In total, these contracts now provide for over \$100 million of targeted mental health services for DCFS children. In addition to these targeted contracts, DMH children's providers also use their general service contracts to provide needed services to DCFS children.

DMH Child Welfare Division staff and service area administrations have begun a series of technical assistance site visits with each of the Katie A. providers to improve their proper utilization of their contracts and maximize their ability to serve DCFS children, and the Child Welfare Division provides monthly reports to providers to monitor their contract utilization. Beginning in January of 2011, quarterly meetings of Katie A. providers will be held to promote improved service delivery and service quality.

DMH has also begun a large scale transformation of mental health services related to the Mental Health Services Act and the Prevention and Early Intervention Program. As part of this initiative, children's mental health providers are being trained in a variety of evidence-based practices, including Trauma-Focused Cognitive Behavior Therapy, Triple P (Positive Parenting Program), Child Parent Psychotherapy, Cognitive Behavioral Intervention for Trauma in Schools, Managing and Adapting Practice, Incredible Years, and Seeking Safety. These practices are expected to significantly improve the quality of children's mental health services and promote improved outcomes.

#### **Wraparound**

Wraparound continues to grow and receive very positive feedback from both families and DCFS regional staff as indicated by the scores on the Wraparound Fidelity Index – version 4 (WFI-4). The full WFI-4 Report will be included in the 2010 Wraparound Annual Report, released in December 2010.

As of November 30, 2010, 1,459 children have been enrolled in Tier II Wraparound, which is ahead of the target (1,325) and a number of the Wraparound providers have begun to hire staff to manage the increased referrals. This past quarter, Tier I enrollments have decreased due to program graduations and disenrollments. The



current census is expected to increase significantly with the implementation of the Residentially-Based Services (RBS) Demonstration Project beginning in December 2010. In addition, DMH completed amendments with a number of Wraparound providers to increase the capacity of the program by an additional 817 Tier II slots for DCFS children.

As reported last quarter, there continues to be discussion about the impact Tier II is having on Tier I. The Wraparound Administration is doing a quality review of Tier II cases to ensure that the Tier II criteria are being applied appropriately. The Wraparound Administration has also implemented a review of the Wraparound Case Rate for appropriateness and opportunities to increase the utilization of EPSDT. In May 2010, a workgroup was formed that included representatives from the CEO, Auditor-Controller's Office, DCFS Finance, Probation, DMH, and several Wraparound Provider agencies. The workgroup developed the methodology and the process for evaluation of Wraparound EPSDT utilization. On October 4, 2010, all Wraparound providers received instructions to provide case rate data for review. To date, all providers have submitted their required information and DCFS Fiscal is processing the data. Upon completion, the Wraparound Administration will analyze report findings and discuss next steps.

### **Treatment Foster Care**

The County's TFC Program is another intensive mental health service program, originally discussed in the Katie A. CAP. The target population for TFC is emotionally or behaviorally challenged youth in, or at risk of placement in, group homes or psychiatric facilities. The goal is to provide intensive mental health services in a less restrictive home-like setting as an alternative to congregate care.

Pursuant to the Findings of Fact and Conclusions of Law Order by Federal District Court Judge, Howard Matz, the County was directed to develop 300 TFC beds by January 2008 and the County has been in the process of implementing 80 Multidisciplinary Treatment Foster Care (MTFC) homes and 220 Intensive Treatment Foster Care (ITFC) homes. A proposal to extend the timelines for full implementation is being discussed by DMH and DCFS managers, County Counsel, Plaintiff attorneys, and Katie A. Advisory Panel members.

Currently, the TFC Program growth is steady as the average number of youth entering a TFC Program each month has sustained at a higher rate (5.3 placements/month) than that of the previous FY (2.3 placements/month). Likewise, just during the first half of FY 2010-11, over 33 youth have entered the program; four more than the 29 who entered during the entire previous FY. As of November 30, 2010, the program reached its highest mark with 44 youth receiving intensive services in TFC settings (26 ITFC and

18 MTFC). In addition, since the last report, the seven youth who transitioned out of a TFC program continued the positive trend of graduating to a lower level of care rather than returning back to a group home or psychiatric facility at a rate of 2 to 1 (with the MTFC program slightly outperforming ITFC).

There has also been a significant increase of certified TFC homes since the last report. Twenty-two homes have been added, bringing the total number of certified homes to 69 by the end of November 2010 (35 ITFC and 34 MTFC) with 26 additional homes in the certification process (20 ITFC and 6 MTFC). With added technical assistance from the Los Angeles County Community Development Team (CDT) and out of county MTFC experts, the MTFC Program is reaching its target goal of 80 slots quickly.

The challenge for both TFC Programs, however, remains the length of time needed to recruit, certify, and train potential TFC resource families. Recruiting foster homes is a challenge faced across the State. Once a family is recruited, it can then take between two to six months to complete the consolidated home study and 40 hours of State mandated TFC training to become fully certified. In an attempt to facilitate this process, the DCFS and DMH TFC Program staff is providing additional direction in recruitment strategies and troubleshoot barriers to certification.

#### **ITFC SUCCESS STORY**

In October 2010, an ITFC foster parent was awarded legal guardianship for two ITFC siblings who had been in her home for over a year. This foster parent was not only committed to offering a permanent home for these youth, she (along with the ITFC treatment team) worked diligently to develop a positive and ongoing relationship with their mother who was recently released from prison. The paradox of many positive ITFC outcomes, such as this, is that the children obtain a permanent home while the ITFC Program loses a certified home in the process.

<b>Table 3: TFC Placement and Capacity (as of 11/30/2010)</b>					
<b>Agency</b>	<b>No. of Placed Children</b>	<b>Certified Homes</b>	<b>Certified Homes Vacancies</b>	<b>**Inactive Homes</b>	<b>Upcoming Beds</b>
<b>Intensive Treatment Foster Care (ITFC)</b>					
Five Acres	10	15	2	3	5
ChildNet	6	7	1	0	1

<b>Table 3: Continued - TFC Placement and Capacity (as of 11/30/2010)</b>					
<b>Agency</b>	<b>No. of Placed Children</b>	<b>Certified Homes</b>	<b>Certified Homes Vacancies</b>	<b>**Inactive Homes</b>	<b>Upcoming Beds</b>
Olive Crest	2	2	0	0	1
Penny Lane	2	3	2	0	6
Aviva	0	0	0	0	0
Rosemary's Children Serv.	0	1	1	0	0
The Village	3	3	0	0	4
CII	0	1	1	0	1
David and Margaret	0	0	0	0	1
Vista Del Mar	1	1	0	0	1
Hathaway-Sycamore	0	0	0	0	0
Ettie Lee	2	2	0	0	0
<b>SUB TOTAL</b>	<b>26</b>	<b>35</b>	<b>7</b>	<b>3</b>	<b>20</b>
<b>Multi-dimensional Treatment Foster Care (MTFC)</b>					
CII	5	7	0	0	0
Penny Lane	8	17	0	10	6
ChildNet	2	5	3	0	0
David and Margaret	3	5	0	2	0
<b>SUB TOTAL</b>	<b>18</b>	<b>34</b>	<b>3</b>	<b>12</b>	<b>6</b>
<b>GRAND TOTAL</b>	<b>44</b>	<b>69</b>	<b>10</b>	<b>15</b>	<b>26</b>

\*\*Per Agency Request

### **OBJECTIVE NO. 3**

#### ***Funding of Services/Legislative Activities***

The FY 2009-10 Katie A. budget closed with \$22 million in net County cost savings. The savings are primarily due to vacant Wraparound slots. If the upward trajectory of filling Wraparound slots continues, the proportion of Katie A. savings should decline in the out years. As we have done with prior year savings, CEO has rolled the FY 2009-10 savings into a Provisional Financial Uses to offset fiscal commitments in FY 2010-11 and FY 2011-12 in support of the incremental rollout of the Strategic Plan.

The settlement negotiations with the State of California led by Special Master, Rick Saletta, have continued for the past 1 ½ years. Although the transition of the Governor's office has slowed the process, it is now anticipated that a settlement agreement with the State will be reached by the end of the calendar year or early 2011. DMH has continued to participate in the negotiations and this forum remains the County's most viable opportunity to maximize revenue reimbursement to the County.

### **OBJECTIVE NO. 4**

#### ***Training***

DMH and DCFS have worked closely together to develop and implement the necessary training components related to the Strategic Plan, including:

- On December 3, 2010, DCFS CWMHS provided DCFS 101 and Real Time Notification training to approximately 140 DMH PMRT staff.
- On October 26, 2010, the DMH Child Welfare Division hosted a Katie A. Training overview for DMH district chiefs, managers and supervisors. The DCFS Katie A. Training manager along with a presenter from the California Institute of Mental Health (CIMH) discussed DCFS and DMH CPM trainings, Coaching and Mentoring training for line supervisors, CSAT, and the Enhanced Skill-Based Training (ESBT). All SPAs were represented and informed the details of the continued rollout of the Katie A. training initiatives.
- On behalf of DMH, CIMH will present a one-day Countywide CPM training on February 10, 2011, focusing on key mental health interventions, including Trauma Informed Practice, Engagement, and Strengths/Needs-Based mental health assessments. In addition, CIMH will provide four half-day training

sessions and ongoing phone consultation in each SPA for DMH co-located staff and community providers supported by coaching and case consultation.

- An ER specific Coaching Model has been developed in partnership with California State University, Long Beach. The initial round of ER coaching for Cohort 1 offices will be completed by:
  - Lakewood and Compton: December 14, 2010; Wateridge and Pasadena: December 16, 2010; Chatsworth: December 21, 2010; and Cohort 2 offices (Torrance, Vermont Corridor, Palmdale, Pomona, and Metro North) by January 25, 2011.
- The ESBT for line supervisors began on December 1, 2010 and training for line CSWs will begin on January 11, 2011. The Continuing Services staff coaching begins on January 25, 2011. This core training will provide staff with key skills and techniques to become office-based coaches with back-end staff.
- The DCFS/DMH CPM desk guide will be refined and adapted into a desk guide that aligns both departments' policies and procedures for ER and Continuing Services staff. In addition, the CPM desk guide will articulate how staff will integrate the key competencies of engaging and teaming, while using a strengths-based approach into daily practice.

## **OBJECTIVE NO. 5**

### ***Caseload Reduction***

The DCFS total out-of-home caseload has been reduced from 15,680 (January 2010) to 15,650 (October 2010). Under the Title IV-E Child Welfare Waiver Capped Allocation Demonstration Project, this allows the Department to redirect dollars to much needed services to strengthen families and achieve safety, permanency, and well-being.

The individual CSW generic caseload average in October 2010 was 24.97, which is a decrease of 0.5 children per social worker from the July 2010 average of 25.47. The ER caseload showed a significant decrease in July 2010, which brought the referral average to 15.19. The October 2010 average of 17.10 demonstrates the increased number of Child Protection Hotline referrals, an increase in ERCP follow-up referrals, associated workload tied to increased safety measures in emergency response activities and investigations, and the need to address an increasing backlog of emergency response investigations.

## **OBJECTIVE NO. 6**

### ***Data and Tracking of Indicators***

The departments, with approval from County Counsel, implemented a plan for sharing protected data sources to track all DCFS referrals for mental health services and provide information regarding service delivery. The SAS Dataflux system is being used for matching DMH and DCFS client data. The SAS Dataflux system is now in full production, whereby matches are being conducted weekly.

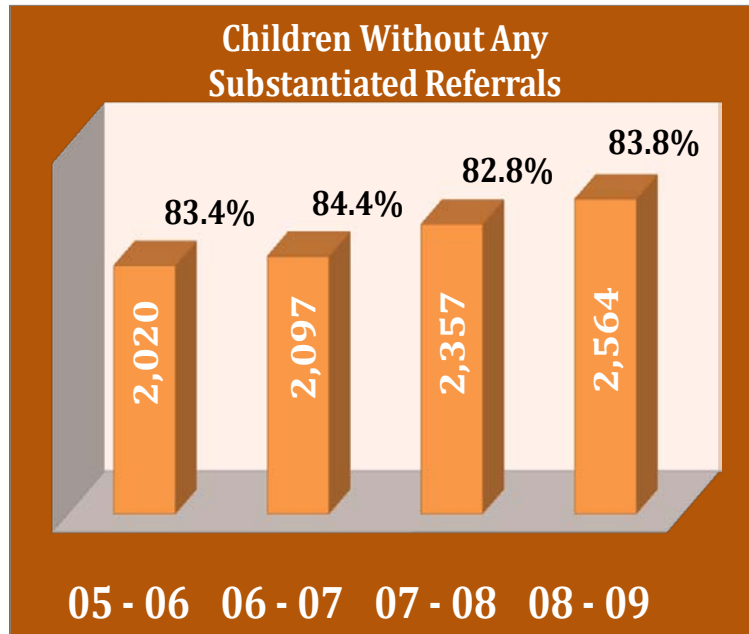
Discussions on the exit indicators continue. Should the Court agree with the County and Panel's recommendations on the Safety and Permanency Exit Indicators and targets, the first step in identifying measurable exit criteria by which to evaluate the County's progress in complying with the Katie A. lawsuit would be accomplished.

### **DATA OUTCOMES**

#### **SAFETY**

#### **PERMANENCY/ REDUCED OUT-OF-HOME CARE**

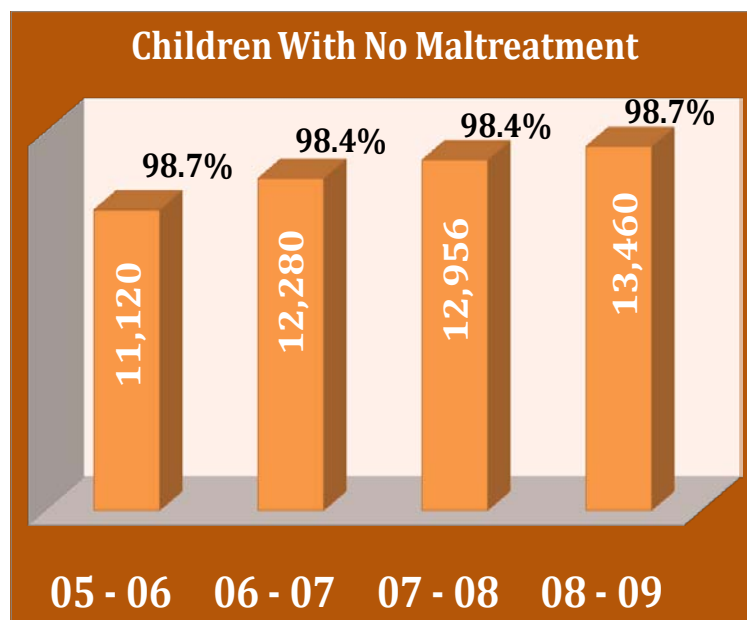
The intensified collaboration of the departments to advance the objectives of the Strategic Plan simultaneously impacts DCFS key goals to: 1) improve child safety; 2) decrease timelines to permanency and reduce reliance on out-of-home care; and 3) improve child well-being. A sample of Katie A. Safety and Permanency Exit Indicators for class members (those receiving mental health services) are depicted below and have not changed since the last quarterly report in September 2010.



**Safety Indicator 1:**

*Percent of cases where children remained home and did not experience any new incident of substantiated referral during case open period while receiving mental health services, up to 12 months.*

*This indicator has remained fairly stable over the last few years at roughly 83 percent and demonstrates that the majority of children are remaining safely at home.*



**Safety Indicator 2:**

*Of all children served in foster care in the fiscal year receiving mental health services, how many did not experience maltreatment by their foster care providers?*

*Again, this indicator has remained stable at 98 percent indicating that the majority of children in foster home settings experienced no substantiated foster parent maltreatment.*

**Permanency Indicator 1:**

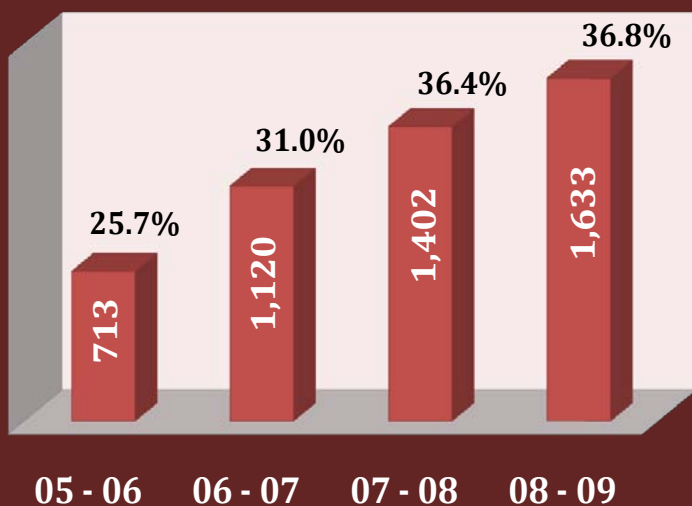
*Median length of stay for children in foster care receiving mental health services.*

*This indicator reflects meaningful improvement – a 23 percent decline – in median days in foster care from FY 2005-06 to FY 2008-09.*

**Median Length of Stay**



**Reunification Within 12 Months**



**Permanency Indicator 2:**

*Reunification within 12 months for children receiving mental health services.*

*Dramatic improvements in reunification are evident – over 100 percent increase from FY 2005-06 to FY 2008-09.*



## **OBJECTIVE NO. 7**

### ***Exit Criteria and Formal Monitoring Plan***

The Strategic Plan identifies three formal exit criteria, including the: (1) successful adoption by your Board and the Federal District Court of the Strategic Plan; (2) acceptable progress on a discrete set of agreed upon data indicators; and (3) a passing score on the Quality Services Review (QSR).

#### **Quality Services Review**

The QSR provides an in-depth, case-based review of the front-line DCFS practice in specific locations and points in time. The QSR utilizes a combination of record reviews, interviews, observations, and deductions made from fact patterns gathered and interpreted by certified reviewers regarding children and families receiving services. The QSR is not a tool used for compliance enforcement, as its feedback is used to stimulate and support practice development and capacity building efforts leading to better practice results for DCFS children and families.

The QSR protocol examines recent results for children in protective care and their caregivers, the contribution made by local service providers and the system of care in producing those results. In addition, the QSR protocol contains qualitative indicators that measure the current status of the focus child, and the child's parents and/or caregivers, while also measuring the quality and consistency of core practice functions used in the case.

A total of 42 cases have been randomly selected for review since July 2010. An average of 8.8 children, youth, caregivers, family members, service providers, and other professionals were interviewed per case and the results have been consistent across the three DCFS offices reviewed – Belvedere, Santa Fe Springs, and Compton. Overall, the children in the cases reviewed were found to be safe, healthy, and well cared for. On the Child and Family Status Indicators, close to 80 percent of the cases had favorable outcomes, with 100 percent of the children identified as being safe in the home of the parent or substitute caregiver at the time of the review. The Practice Performance Indicators identified areas for improvement, including Engagement, Teaming, and Long-Term View. Other factors that were found to have an impact on outcomes included the positive correlation between case outcomes and continuity of the CSW; the utilization of trauma informed evidenced-based treatments; the completion of early assessments that address underlying needs of the child and family; implementing a team approach to treatment; and developing a shared vision with clear goals to be

achieved for safe case closure. Review findings are currently being utilized by local DCFS leaders and practice partners to stimulate and support efforts to improve practice.

QSR Phase II activities, which are to be completed by December 2012, have begun, including the commencement of the administration of the QSR across the 18 DCFS regional offices. The initial sequence of offices to undergo reviews in 2011 has been identified and the rollout is expected to generally follow the order of the CSAT implementation and Enhanced Skill-Based Training. The 2011 QSR schedule includes eight reviews beginning in the DCFS Vermont Corridor Office, January 24-28, 2011. DCFS and DMH are on target to meet the projected time frames to issue the QSR findings and a final report in December 2012, in compliance with the Katie A. Settlement Agreement. QSR Phase III activities, to be completed by December 2013, will consist of any follow-up reviews that may be necessary to achieve passing scores.

QSR reviews have provided an opportunity to understand what is working well and where there is an opportunity for growth. DCFS and DMH have been developing a shared CPM, Enhanced Skill-Based Training, and Coaching and Mentoring Program, so there is a consistent method of practice in working with children and families. In addition to these change strategies, the departments are implementing regional based improvement plans to strengthen practice and ensure quality services.

### **Summary Highlights**

During the last three months, the County has continued to demonstrate significant progress towards meeting the goals of the Strategic Plan and fulfilling the County's obligations related to the Katie A. Settlement Agreement. Katie A. implementation updates will transition to a semi-annual reporting schedule in 2011, with the next report issued on June 30, 2011.

Significant highlights from the last report include:

- DMH has provided contract amendments with Wraparound Providers that will expand the County's capacity to provide Wraparound services for DCFS-involved children and youth by an additional 817 slots;
- DMH and DCFS have begun a series of technical assistance site visits to work with Wraparound Providers and other Katie A. funded mental health programs to improve utilization and reporting of Katie A. related funds;
- The contracts for the RBS Demonstration Project were finalized on December 2, 2010 and the Project is currently operational and serving 49 youth;

Each Supervisor  
December 30, 2010  
Page 27

- A contract amendment has been provided to Exodus to provide mental health crisis stabilization services to DCFS involved children and youth. A coordinated joint response between PMRT and the existing CSW is now occurring for all PMRT field responses for DCFS-involved children during regular work hours. For PMRT field responses to DCFS children who are not hospitalized after regular work hours, a real-time notification and follow-up process by DCFS is currently in place.

Please let me know if you have any questions regarding the information contained in this report, or your staff may contact Kathy House, Assistant Chief Executive Officer, at (213) 974-4530, or via e-mail at [khous@ceo.lacounty.gov](mailto:khous@ceo.lacounty.gov).

WTF:KH  
LB:AM:mh

c: Executive Office, Board of Supervisors  
County Counsel  
Children and Family Services  
Mental Health